Integrated Behavioral Health and Primary Care

MHSOAC Prevention & Early Intervention In-Service Training

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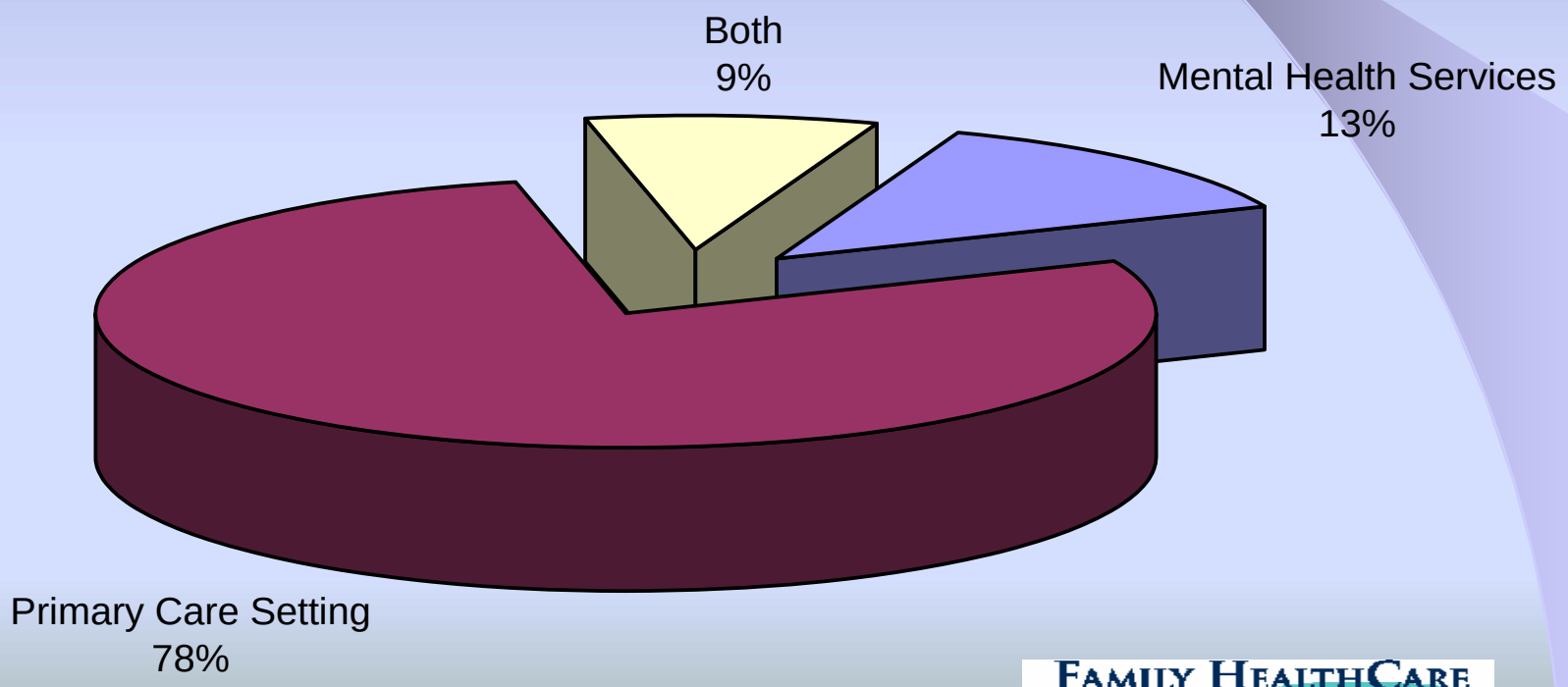
Worldwide approximately 78% of persons with mental health disorders are managed in primary care settings.

(Gater, et al , 1991).



- 50% of all mental health care is delivered by Primary Care Provider (PCP) *(Kessler et al., 1994; Narrow et al., 1993)*
- 92% of all elderly patients receive mental health care from PCP
- Top 10% of healthcare utilizers consume 33% of outpatient services & 50% of inpatient services
- 50% of high utilizers have a mental health or chemical dependency disorder

Source: Kirk Strosahl, Mountain View Consulting

- Only 25% of medical decision making is based on disease severity
- 80-90% of most common complaints have no organic cause
- 67% of psychoactive agents prescribed by PCP
- 80% of antidepressants prescribed by PCP
- Psychosocial distress corresponds with morbidity and mortality risk

Source: Kirk Strosahl, Mountain View Consulting

- In 2004, California's Community Health Clinics (CCHCs) Served 3.4M (3,391,266) Patients
  - 2.8M (2,762,786) under 200% of the FPL
  - 1,123,637 Medi-Cal Patients (includes Medi-Cal & Medi-Cal Managed Care Patients)
  - 944,441 Uninsured Patients

- CCHCs served 14% of California's 6.6 million uninsured
  - Provided 10 million patient visits

Source: OSHPD, Annual Utilization Report of Primary Care Clinics 2004

FAMILY HEALTHCARE NETWORK

- CCHC Patients are from diverse communities
  - 53% Latino
  - 30% non-Latino White
  - 6% Black
  - 6% Asian/Pacific Islander
  - 2% Native American/Alaskan Native
  - 47% are Limited English Proficient

Source: OSHPD, Annual Utilization Report of Primary Care Clinics 2004

- In 2004, California's Community Health Clinics (CCHCs) provided over 805,282 mental health visits annually *(OSHPD Annual Utilization Report of Primary Care Clinics 2004)*

- Of these, over 550,000 were visits to primary care physicians

- This represents approximately 14% of all mental health visits among Californian's under 200% FPL

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- 413 mental health professionals work at CCHCs which include LCSWs, MFTs, psychologists and psychiatrists
- According to a recent member survey, 55% of CCHCs mental health providers are bilingual
- Only a small handful of CCHCs currently have contracts with departments of mental health
- Many CCHCs use an Integrated Primary Behavioral Health Care (IPBHC) Model pioneered by Kirk Stroshal

Integrated Behavioral Health

- The Health Resources Services Administration (HRSA) has designated the integration of behavioral health as a desired service to be provided by Federally Qualified Health Centers (FQHC's)

Vision Statement for HRSA

"... all new grantees [FQHC's] must include plans for increased mental health and substance abuse services. Our ultimate goal is a system of seamless, comprehensive care – where mental health, behavioral health and substance abuse services are linked appropriately in the primary care setting – where the mental health provider is a key member of the entire health care team."

Steve Smith, HRSA Principal Advisor

Remarks to the HRSA-SAMHSA Primary and Behavioral Health Care Summit. December 2004.

FAMILY HEALTHCARE NETWORK

What Does Integration Mean?

- Clinical integration helps us focus on what consumers need
- Financial or structural integration does not assure clinical integration
- Clinical integration requires financial and structural supports in order to be successful

National Council for Community Behavioral Healthcare Consulting

Benefits of Integrated Behavioral Health

- Program design recognizes cultural competence requirement
- Symptoms evaluated using culturally appropriate methods
- Interventions tailored to cultural practice
- Use of community resources supportive of culture
- Services available for mono-lingual patients

Benefits of Integrated Behavioral Health

- Significant, positive results, including:
  1) decreased depression and increase quality of life of older adults,
  2) increased anxiety-free days for people with panic disorders,
  3) decreased in-patient psychiatric admissions,
  4) decreased client stress levels. *(Unutzer, I, et al 2002)*
- High level of patient adherence & retention in treatment, better no show rate even when sick *(Mynors-Wallace et al, 2000)*

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Benefits of Integrated Behavioral Health

- Improved timeliness & access to mental health care
- Intervene early and appropriately to behavioral health issues
- Improved recognition of mental health and chemical dependency disorders *(Katon et. al., 1990)*
- Improved PCP skills in medication prescription practices *(Katon et. al., 1995)*

Benefits of Integrated Behavioral Health

- Improved patient adherence to medication; 50% to 88% *(Katon et. al., 1996)*
- Dramatically reduced "drop out" rates; less than 10% *(Katon et. al., 1996)*
- Improvement in depression remission rates: from 42% to 71% *(Katon et. al., 1996)*
- Improved health status indicators in hypertension; reduced medical costs *(Kent & Gordon, 1998)*

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Benefits of Integrated Behavioral Health

- Improved self management skills for patients with chronic conditions *(Kent & Gordon, 1998)*
- Better clinical outcome than by treatment in either sector alone *(McGruder et. al., 1988)*
- Improved consumer & provider satisfaction *(Robinson et. al., 2000/Bount A. 2003)*
- Improved effectiveness. *(Bount A. 2003)*

Benefits of Integrated Behavioral Health

- Improve health outcomes for patients with costly chronic health conditions such as diabetes, obesity, depression and hypertension
- 20-30% overall cost savings *(Strosahl & Sobel, 1996)*
- 40% in medical cost reduction for Medi-Cal patients receiving targeted treatment *(Cummings & Pallak, 1990)*

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Benefits of Integrated Behavioral Health

- The Medi-Cal Program would save more than $1 million by reimbursing FQHC's, in ***Tulare County***, for both primary care and behavioral health visits occurring on the same day

- The Medi-Cal Program would save more than $98 million by reimbursing FQHC's, ***statewide***, for both primary care & behavioral health visits occurring on the same day

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Benefits of Integrated Behavioral Health

- These savings would be realized by reducing the demand for higher levels of care and decreasing utilization of high-cost service providers

- *This translates to a savings of $5,531,887 in Tulare County and $4,699,940,790 for California as a whole*

The Continuum of Integration

Model	Desirability	Attributes
Separate Space & Mission	- -	Traditional BH Specialty Model
1:1 Referral Relationship	+	Preferred provider/ Some information exchange
Co-location	++	On-site BH Unit/ Separate Team
Collaborative Care	+++	On site/shared cases w/ BH specialist
Integrated Care	+++++	PC Team Member

Primary vs. Specialty Mental Health Models

Dimension	Primary Behavioral Health Care	Specialty Mental Health Care
1. Model of care	1.Population based	1.Patient based
2. Primary customers	1.PCP, then patient	1.Patient, then others
3. Primary goals	1.Promote PCP efficacy 2.Support small patient change efforts 3.Prevent morbidity in high risk patients 4.Achieve medical cost offset	1.Resolve patient's mental health issues
4. Service delivery structure	1.Part of primary care services	1.A specialized service, either in or out of primary care center
5. Who is "in charge" of patient care	1.PCP	1.Therapist
6. Primary modality	1.Consultation model	1.Specialty treatment model
7. Team structure	1.Part of primary care team	1.Part of specialty mental health team
8. Access standard	1.Determined by PCP preference	1.Determined by patient preference
9. Cost per episode of care	1.Potentially decreased	1.Highly variable, related to patient condition

Family HealthCare Network

- Federally Qualified Health Center Organized in 1976
- 9 health centers in Tulare County, 1 health center in Kings County, Central San Joaquin Valley
- Provide family practice, pediatrics, obstetric/gynecology, internal medicine, health education, nutrition and integrated behavioral health services

Family HealthCare Network

- Over 80,000 users, Over 300,000 visits
- Largest JCAHO accredited provider of health services to medically indigent and migrant and seasonal farm workers
- Serve as the Safety Net provider in Tulare County
- Long served and provided mental health services to the residents of Tulare County

- Approximately 7% of the frequent users of Tulare County Emergency Department services access care specifically for mental health problems. *(Kaweah Delta Health Care District. 2004. Frequent Users of Health Program.)*

- Approximately 25% of frequent users of Emergency Departments (ED) access services for ill-defined conditions a large proportion of which probably have a behavioral health component. *(Kaweah Delta Health Care District. 2004. Frequent Users of Health Program.)*

FAMILY HEALTHCARE NETWORK

- 30% of all frequent users of Emergency Department (ED) have a mental health problem *(Kaweah Delta Health Care District. 2004. Frequent Users of Health Program)*

- Teen Admissions to Alcohol and Drug Treatment are 266% the State rate for Tulare County *(California ADP. 2004. Community Indicators of Alcohol and Drug Abuse Risk;Tulare County)*

Integrated Behavioral Health & Primary Care at FHCN

- Implemented in July 2002
- Mission: Manage the behavioral health of the population, all CHC patients
- Focus on improving health of population
  - Emphasis on early identification & prevention
  - Designed to serve high percentage of population
  - Provide triage & clinical services in stepped care fashion

Integrated Behavioral Health: Primary Goals

- Act as consultant & member of health care team
- Build on PCP interventions
- Teach PCP “core” behavioral health skills
- Improve PCP-patient working relationship
- Educate patient in self management skills through training

Integrated Behavioral Health: Primary Goals

- Manage chronic patients & monitor high risk patients with PCP
- Simultaneous focus on health & behavioral health issues
- Effective triage of patients in need of specialty behavioral health
- Make IBH services available to large percentage of eligible population

Integrated Behavioral Health: Outcomes

- Improved recognition of behavioral health needs by PCP
- Improved collaborative care & management of patients with psychosocial issues in primary care
- An internal resource for PCPs to help address psychosocial concerns or behavioral health issues w/out referring to specialty mental health
- Immediate access to Behavioral Health Consultants (BHCs), w/ rapid feedback

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Integrated Behavioral Health: Outcomes

- Improved fit between the care patients seek in primary care and the services offered
- Prevention of more serious mental disorders through early recognition & intervention
- Triage into more intensive specialty mental health care by BHCs
- Increased access to behavioral health care
- Satisfied providers
- Increased PCP productivity

Integrated Behavioral Health Barriers

The most serious issue affecting full integration of primary and behavioral health services in California is the inability to bill both medical and behavioral health visits that occur on the same day and receive reimbursement for both

Integrated Behavioral Health Barriers

- Stifled both innovation & the number of start-ups of integrated primary behavioral health care programs
- Forced closure of behavioral health programs because of un-reimbursable costs associated with providing quality primary behavioral health
- Approximately 30% of FHCN IBH patients are seen the same day for a total of $200,000 in un-reimbursed costs annually

Integrated Behavioral Health Summary

- Integrated Primary Behavioral Health Care Model's (IPBHC) key purpose is the "warm hand-off" from physician to mental health provider

- Issue to solve: Department of Health Services will not reimburse CCHCs for both a medical and behavioral health visit on the same day

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